Prudential

Group Insurance

The Prudential Insurance Company of America
Disability Management Services

Waiver of Premium Unit
P.O. Box 70183, Philadelphia, PA 19176

Tel 800-524-0542 Fax 877-862-0269

Group Life Claim For Total Disability Benefits—Employer Statement

Group Insurance Contract Holder's Statement To be completed by Employer/Plan Administrator. Please complete sections 1-3 and 4 if applicable.

1 Employee Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female

Date of Employment (MM DD YYYY) | Date Last Worked (MM DD YYYY) | Home Telephone Number

☐ Hourly ☐ Salary ☐ Union ☐ Non-Union ☐ Part-Time ☐ Full-Time

Date First Absent (MM DD YYYY) | Date Work Resumed (MM DD YYYY) | Date to Which Salary or Wage Was Paid (MM DD YYYY)

2 Insurance Coverages

Complete only the coverage(s) that apply to this claim.

Group Coverage	Control Number	Amount	Effective Date of Coverage (MM DD YYYY)	Branch
☐ Basic Term Life		$.		
☐ Optional Term Life		.		
☐ Dependent Optional Term Life		.		
☐ Group Universal Life		.		
☐ Group Variable Universal Life		.		
☐ Optional Accidental Death		.		
☐ Dependent Optional Accidental Death		.		
☐ Business Travel Accidental Death		.		

For any optional or supplemental coverages, attach a copy of proof of enrollment

Base Salary Amount on Last Day

$. per ☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned? ☐ Yes ☐ No

If "Yes," please attach a copy of assignment and all related papers. For collateral assignment, please attach Assignee's Statement of Indebtedness.

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Employee's Social Security Number

If earnings include other forms of compensation, please indicate below:

Type of Compensation	Amount	Period From (MM DD YYYY)	To (MM DD YYYY)
☐ Overtime	$.		
☐ Bonus	.		
☐ Other	.		

Description

Has insurance percentage/amount increased in the last two years? ☐ Yes ☐ No If yes, provide date (MM DD YYYY)

Was evidence of insurability required to secure current coverage? ☐ Yes ☐ No Is there contributory insurance? ☐ Yes ☐ No Date Last Premium Paid (MM DD YYYY)

Was insurance in force on last day worked? ☐ Yes ☐ No If no, provide date: Insurance Terminated (MM DD YYYY) Conversion Privilege Offered (MM DD YYYY)

Is this employee covered under an LTD plan administered by Prudential? ☐ Yes ☐ No Control Number

Is this employee covered for Total and Permanent Disability Benefits under this group life insurance policy? ☐ Yes ☐ No

Did this employee elect the payment method, if eligible, prior to their disability? If "Yes," provide proof of election, lump sum, or installment payments. ☐ Yes ☐ No

3 Job Information

Occupation Prior to Disability

Where Employed

Did employee cease work solely due to disability? If "No," check off as applicable below: ☐ Yes ☐ No

☐ Terminated ☐ Leave of Absence ☐ Vacation ☐ Discharge

☐ Resigned ☐ Retired ☐ Temporary Layoff ☐ Other

What Job Category best describes the claimant's functional abilities? (Please check the appropriate box)

☐ **Sedentary**	☐ **Light**	☐ **Medium**	☐ **Heavy**	☐ **Very Heavy**
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and/or Frequent Walk/Stand and/or Constant Push/Pull	Up to 25 lbs. frequently Up to 50 lbs. occasionally	25 to 50 lbs. frequently 50 to 100 lbs. occasionally	More than 50 lbs. frequently 100 lbs. occasionally

☐ **Other** (Please describe)

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Employee's Social Security Number

Street Address (where employed)

Suite

City

State

ZIP Code

Completed by (Please print or type)

Signature of Policyholder's Representative X

Date (MM DD YYYY)

Employer Telephone Number

Email Address

4 Survivor Benefit Information

Survivor Benefit Life Insurance
Marital Status:

☐ Single ☐ Divorced ☐ Widowed ☐ Married

If Married, Date of Marriage (MM DD YYYY)

Amount of Monthly Benefits Payable

Spouse $.

Children $.

Total $.

Family Members (Show information for each)

Relationship	Name	Date of Birth (MM DD YYYY)	Date Reported for Coverage (MM DD YYYY)
☐ Spouse			
☐ Child			
☐ Child			
☐ Child			

Completed by (Please print or type)

Signature of Policyholder's Representative X

Date (MM DD YYYY)

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS— For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW YORK RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NEW JERSEY RESIDENTS— Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PENNSYLVANIA RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS— Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

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